Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $6,113.29 for date of service 02/27/01.
   b. The request was received on 02/26/02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC-60 and Letter Requesting Dispute Resolution
   b. UB-92
   c. TWCC 62 forms
   d. Medical records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:
   a. TWCC-60 and Response to a Request for Dispute Resolution
   b. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307(g)(3), the Division forwarded a copy of the requestor's 14-day response to the insurance carrier on 07/05/02. Per Rule 133.307 (g)(4), the carrier representative signed for the copy on 07/08/02. The response from the insurance carrier was received in the Division on 07/22/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file

III. PARTIES' POSITIONS

1. Requestor: Letter dated 06/25/02:

"…Code Section 133.304 specifically provides 'the explanation of benefits **shall include the correct exception codes**'...On the EOB provided by the Carrier, a blanket application of code 'M' was indicated for each billed amount…code 'M' does not apply to billed amounts that have an established 'MAR'….**Despite prior notification to the Commission and requests by (Provider), to forward this correspondence to their legal representative, the Commission continued to forward this correspondence to the incorrect fax number.**"

2. Respondent: Letter dated 07/22/02:
"The requester believes that it should be paid more because other carriers are paying either 100% or some percentage of its billed charges. As evidence of this the requester submitted EOBs. SOAH…stated that EOBs are some evidence of fair and reasonable but not the evidence, the evidence being the method by which the provider determined that its charged amount is fair and reasonable (not just usual and customary) *and* consistent with statutory standards…. (Carrier) used data from two national resources: 1) ASC charges as listed by CPT code in '1994 ASC Medicare Payment Rate Survey, and 2) ASC Group payment rates as determined by the Secretary of the U.S. Department of Health and Human Services for surgical procedures by CPT code. (Carrier) used this data in the following manner: 1) The payment rate for the service in dispute, as defined by the CPT code, is determined using Medicare's ASC Group rates. 2) The median charge from ASCs, as weighed by total volume, is determined for the service group. 3) The co-payment amount is determined by multiplying the median weighted facility charge by 20%. 4) The dollar amounts from B.1) and B.3) above are summed to determine the fair and reasonable payment for the service. In this dispute (Carrier) took the CPT code used by the surgeon, 64510, and applied its methodology to determine its fair and reasonable payment of $393.00." The (Carrier) referenced the sources used in determining it's methodology.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1&2), the only date of service eligible for review is 02/27/01.

2. The provider billed a total of $6,506.29 for the disputed date of service per the TWCC 60.

3. The carrier reimbursed a total of $393.00 per the TWCC 60 and the denial EOB(s) are "M – FAIR AND REASONABLE FOR THIS ENTIRE BILL IS MADE ON THE 'OR SERVICE' LINE ITEM.";
"M – THE REIMBURSEMENT FOR THE SERVICE RENDERED HAS BEEN DETERMINED TO BE FAIR AND REASONABLE BASED ON BILLING AND PAYMENT RESEARCH AND IS IN ACCORDANCE WITH LABOR CODE 413.011(B)."

4. The amount in dispute per the TWCC-60 for the disputed date of service is $6,113.29.

V. RATIONALE

The medical documentation indicates the services were performed at an ambulatory surgery center. Commission Rule 134.401 (a)(4) states ASCs, "shall be reimbursed at a fair and reasonable rate…" (bolded for emphasis)

The Medical Fee Guidelines General Instructions (VI) discuss that if a MAR value has not been established for a CPT code, reimbursement shall be, "…at the fair and reasonable rate." ASC(s) do not have a MAR value.

Section 413.011(b) of the Texas Labor Code states, "Guidelines for medical services must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fees charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The Commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

Rule 133.307 (g) (3) (D) states, "if the disputes involves health care for which the commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with § 133.1…"

The provider stated in the request for medical dispute letter that EOB(s) from the carrier were submitted to show that the carrier inconsistently reimburses for billed charges with a corresponding "MAR" and that the carrier does reimburse per the TWCC Fee Guideline for billed charges which do have a "MAR". The provider failed to submit any carrier EOB(s) in the dispute packet.

The carrier has submitted sufficient documentation of its methodology and therefore, meets the requirements of Commission Rule 133.304 (i).

Because there is no current fee guideline for ASC(s), the Medical Review Division has to determine what would be fair and reasonable reimbursement for the services provided. Regardless of the carrier's application of it's methodology, lack of methodology, or response, the burden is on the provider to show that the amount of reimbursement requested is fair and reasonable. Based on the evidence available for review, the provider did not meet the criteria of Rule 413.011 (b) or 133.307 (g) (3) (D) and did not prove that the carrier's reimbursement is not fair and reasonable. Therefore, the provider is not entitled to additional reimbursement.

The above Findings and Decision are hereby issued this 8th day of August 2002.

Donna M. Myers, B.S.
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm